considered residents of Mississippi. These providers must provide documentation of their certification for Title XIX and the facility's Medicaid rate for the domicile state. Payment will be made based on the lesser of the Medicaid rate of the domicile state or the maximum Mississippi Medicaid rate for their classification. The maximum Mississippi Medicaid rate for out-of-state providers is defined for nursing facilities as the ceilings for direct care and care related costs paid based on a case mix of 1.000 plus the ceiling for administrative and operating costs and the gross rental per diem payment as computed under the plan. Classifications which have a case mix adjustment will be computed using a case mix score of 1.000 unless the facility submits an MDS+ form (version 12/01/90B) that is classifiable. The case mix adjustment will be applied to the maximum Mississippi Medicaid rate only when the maximum Mississippi Medicaid rate is determined to be lower than the Medicaid rate of the domicile state. The maximum Mississippi Medicaid rate for out-of-state providers is defined for ICF-MR's and PRTF's as the ceiling for direct care, therapies, care related, administrative and operating plus the gross rental per diem as computed under the plan. The maximum Mississippi Medicaid rate for out-of-state providers will not include a

return on equity per diem or a property tax and insurance per diem. The gross rental per diem used in determining the maximum rate will be based on submitted property information from the provider or a thirty year age in the absence of provider information.

Q. Change of Classification

Facilities which undergo a change of classification must file a cost report from the date of the change of classification through the end of the third month of ownership. The Division of Medicaid may shorten or lengthen the reporting period of the initial cost report to not less than one (1) month or not more than four (4) months. Facilities will be paid the maximum per diem rate for their classification until the rate is adjusted based on this initial cost report. The maximum per diem rate is defined as the maximum base rate for direct care and care related costs, allocated between the two cost centers based on the cost report filed under the previous classification that was used to compute the rate in effect on the date of the change of ownership, and adjusted for the case mix for the appropriate calendar quarter, plus the ceiling for administrative and operating costs, plus the gross rental per diem payment computed under the fair rental system as defined by this

plan. The facility will receive a return on equity capital per diem and a property tax and insurance per diem based on the cost report filed under the previous classification that was used to compute the rate in effect on the date of the change of classification. The rate computed based on the initial cost report of the new classification will be effective the same date the change of classification was effective.

1-4 Resident Fund Accounts

Nursing Facilities, ICF-MRs, and PRTFs must account for the facility's resident fund accounts in accordance with policies and procedures adopted by the Division of Medicaid. These policies and procedures are contained in the appropriate provider manuals. Audits will be conducted of all resident fund accounts each year. Results of the audits will be reported to the Mississippi State Department of Health, Division of Health Facilities Licensure and Certification.

1-5 Admission, Transfer, and Discharge Rights

The facility must establish and practice admission, discharge, and transfer policies which comply with federal and state regulations. Long-term care facilities that participate in the Medicaid program are prohibited from requiring any resident or any resident's family member or representative to give a notice prior to discharge in order to require payment from that resident, family member or representative for days after the discharge date.

1-6 Payments to Providers

A. Acceptance of Payment

Participation in the Title XIX Program will be limited to those providers which agree to accept, as payment in full, the amounts

paid by the Division of Medicaid plus any deductible, coinsurance or co-payment required by the plan to be paid by the individual for all covered services provided to Medicaid patients.

B. Assurance of Payment

The State will pay a certified Title XIX long-term care facility with a valid provider agreement, furnishing services in accordance with these and other regulations of the Mississippi Medical Assistance Program in accordance with the requirements of applicable State and Federal regulations and amounts determined under this plan. Payment rates will be reasonable and adequate to meet the actual allowable costs of a facility that is efficiently and economically operated.

C. Upper limit based on Customary Charges

In no case may the reimbursement rate for services provided under this plan exceed an individual facility's customary charges to the general public for such services, applied in the aggregate, except for those public facilities rendering such services free of charge or at a nominal charge. Should a facility receive the notice of their Medicaid rate less than thirty (30) days prior to the effective date of the rate, the facility should adjust the private pay rate no later than sixty (60) days following the receipt of the rate notification in order to comply with this limit.

D. Overpayments

An overpayment is an amount which is paid by the Division of Medicaid to a provider in excess of the amount that is computed in accordance with the provisions of this plan. Overpayments must be repaid to the Division of Medicaid within sixty (60) days after the date of discovery. Discovery occurs either (1) on the date the Division of Medicaid first notifies a provider in writing of an overpayment and specifies a dollar amount that is subject to recovery, or (2) on the date a provider acknowledges an overpayment to the Division of Medicaid in writing, whichever date is earlier. Failure to repay an overpayment to the Division of Medicaid may result in sanctions described in Section 1-7 of this plan.

Overpayments documented in audits will be accounted for on the Form HCFA-64 Quarterly Statement of Expenditures not later than the second quarter following the quarter in which the overpayment was found.

E. Underpayments

An underpayment occurs when an amount which is paid by the Division of Medicaid to a provider is less than the amount that is the amount computed in accordance with the provisions of this plan. Underpayments will be reimbursed to the provider within sixty (60) days after the date of discovery.

F. Credit Balances

A credit balance on a provider's account is an amount which is due to the Division of Medicaid. The credit balance is treated as an overpayment by the Division of Medicaid and is subject to the rules described above in D. for overpayments.

1-7 Appeals and Sanctions

A. Appeal Procedures

Long-term care providers who disagree with an adjustment to their allowable costs made as a result of a desk review or an audit may file an appeal to the Division of Medicaid. The appeal must be in writing, must include the reason for the appeal, and must be made within thirty (30) calendar days after notification of the adjustment. The Division of Medicaid shall respond within thirty (30) calendar days after the receipt of the appeal.

Long-term care providers who disagree with an adjustment to the Minimum Data Set (MDS) that changes the classification of the resident to a different M^3PI group than the M^3PI group originally determined by the facility may file an appeal to the Division of Medicaid, Case Mix Office. These adjustments may have been made by either a desk review or an on-site visit. The appeal must be in writing, must contain the reason for the appeal and any supporting documentation, and must be made within thirty (30) calendar days after the provider was notified of the adjustment. The Division of Medicaid, Case Mix Office shall reply within thirty (30) calendar days after the receipt of the appeal.

The provider may appeal the decision of the Division of Medicaid in matters related to cost reports, including, but not limited to, allowable costs and cost adjustments resulting from desk reviews and audits to the Review Board in accordance with the provisions of Miss. Code Ann. Section 43-13-117.

The provider may appeal the decision of the Division of Medicaid in matters related to the Minimum Data Set (MDS) including but not limited to audits, classifications and submissions to the Review Board in accordance with the provisions of Miss. Code Ann. Section 43-13-117.

Notices and responses shall be delivered by certified mail, return receipt requested, overnight delivery by a private carrier, or by hand delivery, and shall be deemed to have been received (a) if by certified mail or overnight mail, on the day the delivery receipt is signed, or (b) if by hand delivery, on the date delivered.

The action of the Division of Medicaid under review shall be stayed until all administrative proceedings have been exhausted.

Appeals by nursing facility providers involving any issues other than those specified above in this section shall be taken in accordance with the administrative hearing procedures set forth in Miss. Code Ann. Section 43-13-121(4).

B. Grounds for Imposition of Sanctions

Sanctions may be imposed by the Division of Medicaid against a provider for any one or more of the following reasons:

a. Failure to disclose or make available to the Division of Medicaid, or its authorized agent, records of services provided to Medicaid recipients and records of payment made therefrom.

b. Failure to provide and maintain quality services to Medicaid recipients within accepted medical community standards as adjudged by the Division of Medicaid or the MS Department of Health.

c. Breach of the terms of the Medicaid Provider Agreement or failure to comply with the terms of the provider certification as set out on the Medicaid claim form.

d. Documented practice of charging Medicaid recipients for services over and above that paid by the Division of Medicaid.

e. Failure to correct deficiencies in provider operations after receiving written notice of deficiencies based on classification of severity and scope as proposed in 42 CFR Subpart F, section 488.204 from the Mississippi State Department of Health or the Division of Medicaid.

f. Failure to meet standards required by State or Federal law for participation.

g. Submission of a false or fraudulent application for provider status.

h. Failure to keep and maintain auditable records as prescribed by the Division of Medicaid.

i. Rebating or accepting a fee or portion of a fee or charge for a Medicaid patient referral.

j. Violating a Medicaid recipient's absolute right of freedom of choice of a qualified participating provider of services under the Medicaid program.

k. Failure to repay or make arrangements for the repayment of identified overpayments, or otherwise erroneous payments.

l. Presenting, or cause to be presented, for payment any false or fraudulent claims for services or merchandise.